COVER PAGE

Submitted To:
State of Arizona Department of Health Services
Request No: HF332025

Subject:
Greater Arizona Behavioral Health Services

Submitted By:
Magellan Complete Care of Arizona, Inc.
4801 East Washington Street, Suite 100
Phoenix, AZ 85034
(602) 652-5900
(800) 564-5465

Submission Date:
January 21, 2014

Designated Contact:
Contact Name: James R. Stringham
Contact Title: Senior Vice President
Phone: (602) 652-5955
Email: JRStringham@magellanhealth.com

5. REQUEST FOR INFORMATION INPUT

ADHS and AHCCCS request a response to the following questions. (A response to all of these questions is not a requirement.)

5.1. What opportunities exist for restructuring the Greater AZ GSAs? What regional geographical approach should the state consider when creating the RFP? North, South?

Opportunities for Restructuring the Greater Arizona GSAs

Community Health Assessments conducted via the Managing for Excellence Program (MEP) in 2012 and 2013 in each county in Arizona revealed common themes across the rural counties of the state. Among these themes are unique cultural considerations and needs such as varied traditions and languages amid 22 different tribes across the state; shortages of healthcare professionals (primary care physicians, specialty providers, and others); limited access to care due to transportation barriers; substance abuse; and preventable chronic health conditions, such as diabetes and obesity.

By restructuring the Greater Arizona GSAs into two regions, one North and one South, efficiencies and expanded service capacity would be achieved by virtue of economies of scale. Rural counties would stand to benefit from access to a larger network of service providers, thus positively impacting access to care. Contracting for transportation services could be managed more cost-effectively based upon volume and standardized rates for non-emergency, medically necessary transportation services. Promotion of healthy lifestyle choices through health screenings and education on prevention and chronic disease self management could be developed and/or promulgated across each of the two regions, making use of existing resources (curricula, telemedicine systems, etc.) from within the more populous urban areas of each region.

In the North, the US Census Bureau data indicates an approximate population of just fewer than one million people when combining the six Northern counties (Mohave, Coconino, Yavapai, Navajo, Apache, and Gila). By combining this region not only is there a natural economy of scale in addition there are shared demographics in these regions that are largely represented by the Native American and White populations. These regions also represent a diverse array of native languages spoken second to English. Another relevant demographic data point is the representative proportion of individuals under 18 and over 65. This plays a role in designing and maximizing a provider network continuum and in building models for accessing and delivering care.

In the South, the US Census Bureau data indicates an approximate population of 1.6 million people when combining the eight Southern counties (La Paz, Yuma, Pima, Pinal, Santa Cruz, Cochise, Graham, and Greenlee). Similar to the Northern region, the Southern counties share demographic themes and are largely White and White Hispanic with a large percentage of Spanish-speaking communities. Although this region has a large urban hub within a rural part of the state, there is a shared theme of high rates of poverty, chronic conditions, unemployment and teen birth rates compared to the state as a whole. These themes equally play a role in designing and maximizing a provider network continuum and in building models of accessing and delivering care.

As highlighted in **Figure 5.1.a**., the proposed geographic service area designations will maximize resources and service providers who share a common understanding and expertise around the cultural, economic and public health needs of the community. Therefore this recommendation would ultimately result in economy of scale across each region.

Figure 5.1.a. Proposed Geographic Service Area Designations

In the North, the US Census Bureau data indicates an approximate population of just fewer than one million people when combining the six Northern counties (Mohave, Coconino, Yavapai, Navajo, Apache and Gila).

In the South, the US Census Bureau data indicates an approximate population of 1.6 million people when combining the eight Southern Counties (La Paz, Yuma, Pima, Pinal, Santa Cruz, Cochise, Graham and Greenlee).

5.2. In the event that the state opts to consolidate Greater Arizona's existing regions and to select two (2) vendors to serve Greater Arizona in whole, what would the benefits, challenges and risks be?

Benefits, Challenges, and Risks to Consolidating Greater Arizona's Existing Regions and Selecting Two Vendors

We do not believe this approach would be advantageous to the members, because the Northern and Southern regions of the state, although sharing some rural characteristics, are significantly different. Therefore, we reassert our recommendation to develop two regions, North and South.

Under the current GSA structure, there is significant overlap between RBHAs contracting with the same provider organizations, particularly for residential treatment, including supported housing and HCTC, and specialty services for which no provider (or no capacity) is available within the GSA. This creates a scenario in which RBHAs compete for the same beds, resulting in members being placed in facilities at great geographic distance from their families and support systems. However, if the GSAs were reconfigured to a North region and a South region, each of the two regions would be expected to identify network sufficiency gaps and to develop capacity within the region to address the needs of members. Development of additional licensed capacity by existing service providers is more manageable and more potentially attractive to provider organizations if there is a stronger referral base, as would be the case with larger memberships in each of the two regions as compared to membership in the existing smaller GSAs.

An added benefit to the economies of scale and efficiencies that can be achieved with a North and South region design is the elimination of confusion for members, stakeholders, and providers would experience working with one company versus multiple vendors. For members there would be one telephone number, one local crisis system/line, and one plan managing their full array for service options. This would still allow for choice where it is most important for the member—at the service level. The challenges would include the potential for inconsistencies of practice and disparities in quality of care between the two RBHAs. This in turn, requires oversight on the part of the state to ensure members' needs are being met equitably across regions as well as to create the infrastructure for enrollment brokerage, auto-assignment, and so on for the behavioral health services.

The recommendation of one RBHA per North and South regions would allow for a single source of direct accountability around oversight and management of the service continuum and quality of care, reduce duplicate administrative structures and costs, ensure providers are not having to navigate two RHBA contractual arrangements, and allow for sufficient population density to ensure fiscal viability of the RHBA.

5.3. What are challenges and opportunities of establishing the following Term of Contract options:
5.3.1.1. Three (3) years subject to one (1) additional successive period of twenty-four (24) months;
5.3.1.2. Five (5) years subject to one (1) additional successive period of twenty-four (24) months;
5.3.1.3. Three (3) years subject to two (2) additional successive periods of twenty-four (24) months each.

The Term of Contract option 5.3.1.2 Five (5) years subject to one (1) additional successive period of twenty-four (24) months would be in the State's best interest. Large-scale change (as this RFI suggests) requires four to five years for system change. This time frame allows for the institutionalization of changes and provides sufficient time to fully implement system

transformation. This contract term also provides sufficient time to develop a baseline for meaningful measurement of outcomes related to health, wellness, and recovery.

5.4. What are the implications of the State implementing a statewide crisis system? How can crisis services be more effectively delivered in Greater Arizona?

Greater Arizona Crisis System

While there is no disputing that crisis services and coordination can be enhanced and best practices can and should be deployed to improve care with the goal of community stabilization, operating a state-wide crisis system is not the most effective way of accomplishing this task. Focus should be on better defining what critical services are required to operate and manage an effective crisis system which serves the needs of members. Establishment of guiding principles and engaging key stakeholders in shaping service delivery in local communities is critical to providing effective services. This can only be done by working with those closest to the crisis system: members, their families, first responders, and other system partners.

Targeted approaches in diverse and rural communities need to be adapted to address unique factors of each region, leveraging local resources to provide necessary services and offering consultation and support specific to those members accessing care.

The crisis system is often the entry point to the service delivery system. Bifurcating the crisis system from the rest of a regional system of care will result in poor coordination, delays in identification and follow up, and limit the ability to track service utilization and gaps. Careful coordination and protocols at the regional level with critical stakeholders such as law enforcement, fire, emergency rooms personnel, and community providers is the linchpin to a well functioning crisis system. Management of these critical relationships, which need to occur in the communities where services are rendered, is not feasible on a state-wide basis.

Additionally, a comprehensive crisis service delivery model encompasses more than just the traditional crisis call, urgent care, inpatient, and mobile crisis teams. An effective crisis system requires a seamless link with all the ancillary outpatient, assessment, and peer and family crisis support services essential to assisting the member to navigate the crisis system. To ensure timely access by members to least restrictive care, the crisis system should not be carved out to a separate vendor from the single RHBA health plan.

For example, Crisis Intervention Team (CIT) training for Law Enforcement personnel has standardized processes in place but must also be designed to consider the unique needs, resources, and stakeholders of the community in which they operate and require deep and enduring community relationships with law enforcement and first responders, a strategy which we believe will be hampered by a single state-wide system in which divergent, emergent priorities across regions can often divert energy from local commitments and relationship-building.

5.5. Are there unique opportunities or challenges present in the Greater Arizona geographic area when it comes to integration of care? How would your organization maximize or minimize the opportunities or challenges? What models should be considered?

Maximizing the Opportunities and Minimizing the Challenges for the Integration of Care

Integration of care requires careful planning, cooperation, and communication with stakeholders who have been receiving services under a different service model. There are opportunities for integration of care based upon the maturity of the behavioral health system and its providers, relationships that can be built into the existing GSAs that comprise Greater Arizona.

Challenges include ensuring that medical providers are motivated to work to integrate care and the need to communicate the changes to all stakeholders who are accustomed to a different system. Issues characteristic of rural areas that will be part of Greater Arizona include the presence of a larger proportion of elderly individuals, poorer general health status, transportation issues, higher suicide rates (especially in the elderly population), fewer service providers (including medical professionals and specialty behavioral health service providers, such as birth-to-five, sex offender, and developmental disability).

We suggest that the state request potential RFP bidders to recommend and provide demonstration of their integration models that can be utilized effectively in Greater Arizona.

5.6. What challenges exist for the RBHA to be a Dual Eligible Special Needs Plan? Describe the challenges and opportunities in establishing a Medicare Network in Greater Arizona?

Challenges for the RBHA to Be a Dual Eligible Special Needs Plan

In general, we do not see the RHBA having challenges that differ from those of the traditional health plan. In fact, we have shown in Maricopa that it is achievable and possible to develop a Dual Eligible Special Needs Plan (D-SNP) that meets all the requirements of AHCCCS and CMS and receives a perfect score of 100 percent from CMS for its model of care. Rather, we see tremendous advantages to the member and the network of having a knowledgeable and trusted behavioral health-led D-SNP. We, likewise, do not see any challenges in contracting with a fully compliant network of providers.

In both the North and the South regions, there are existing D-SNP and contracted networks where all of the members with a serious mental illness are current enrolled. It is our belief and experience in Maricopa that the existing networks welcome the opportunity to contract with a resident expert in behavioral health care management who can provide additional support for the physical health practitioners and members. In fact, it is anticipated that the trusted behavioral health-led D-SNP will be more successful in engagement and integration of physical and behavioral health services given their long-standing expertise in the issues of recovery, social connection, social determinants of health, member engagement, and peer and family support.

The challenges that exist are present for any new D-SNP and for a D-SNP specifically focused on members suffering from a serious mental illness. The total number for members with a serious mental illness in the North and the South regions is low considering the costs of running a D-SNP. Generating membership sufficient to make it fiscally viable may be difficult. This is further complicated by the fact that CMS has not allowed Arizona to passively enroll members into the

SMI D-SNP, a practice which would have assured a full and stable membership enrollment. Therefore, any D-SNP will have marketing challenges attempting to attract members away from their current plans, which they may have had for some time, into the RHBA D-SNP. It is anticipated that if the RHBA is being led by behavioral health that the marketing may be easier given the familiarity and sensitivity of behavioral health RHBAs to the issues facing the recovery of members with a serious mental illness.

Finally, any D-SNP focused on the population with SMI will also face the challenge of adequate rates from CMS. To date, CMS has not addressed the inadequacy of risk adjustment methodology for the Medicare FFS rates and Medicare Advantage bids. Individuals with SMI have claims experience significantly higher than their CMS HCC risk-adjustment score variation would account for, based upon actual Medicare sample data.

5.7. When it comes to service delivery, how will your organization utilize regional and cultural diversity to its maximum advantage in order to provide physical and behavioral health care in Greater Arizona?

Delivering Maximal Physical and Behavioral Health Care Using Regional and Cultural Diversity

Regional cultural diversity is critical in providing physical and behavioral health care. The state should ask and expect potential RFP bidders to complete a thorough analysis of the data and respond accordingly with their experience and plan for implementation.

5.8. What services would be most critical to fund using general fund state-only dollars?

Determining the Most Critical Services to Fund

As individuals convert from the NTXIX benefit to TXIX due to Medicaid Restoration or as they qualify for healthcare benefits on the Exchange, general fund state-only dollars will become available for other uses. As discussed with ADHS/DBHS and the current RBHA system, there are two overarching approaches:

1) General fund state-only dollars are reserved to augment currently covered services that will not be captured on the Health Insurance Exchanges. These services may include peer support, supported housing, supported employment, rehab services, and some case management services relating to ACT for SMI.
2) General fund state-only dollars are to be designated for the stabilization and/or expansion of non-Medicaid covered services essential for an individual's recovery such as housing or expanded use of flex funds.

In order to be able to evaluate the application of these funds, the RFP should outline the key expectations of the state to ensure the principles of the Arnold Settlement and System priorities are maintained. Based on these expectations, the bidder should respond by describing their proposed model(s) for stabilizing and expanding services in accordance with the unique clinical and cultural needs of each designated region.

5.9. What are the barriers or challenges to care coordination in the current service delivery system in Greater Arizona, and what could be done to improve care coordination, particularly at transition points for high utilizers (discharge from inpatient, release from jail, and children transitioning to and from the Comprehensive Medical and Dental Program)?

Improving Care Coordination in the Current Service Delivery System

The large geographic spread of many of the communities in greater Arizona and variable transportation availability are among the challenges to coordinate care. Coordinating care at "transition point" for high utilizers includes the following:

- entry back into the community when jail or inpatient care has resulted in consumers leaving their communities
- ensuring that care is delivered immediately in a community-based environment, particularly for continuity of medication management
- coordinating discharge planning with jail/prison and hospital case management personnel.

Designing a system to ensure that care is coordinated and consumers do not "slip through the cracks" for receiving integrated medical and behavioral healthcare requires experience, an understanding of the elements of the current delivery system, and thorough demographic and utilization data for the members of the current RHBAs who will constitute the Greater Arizona RHBA configuration.

5.10. What specific measures and processes should be used to evaluate access to care and improved outcomes?

The current RBHA contracts offer ADHS- and AHCCCS-approved criteria to measure access to care and improve access to care outcomes, standards that are aligned with the National Outcome Measures, standards for integration, and CMS Medicare standards. These standards are more than adequate and should be continued, as with close monitoring, target initiatives and close provider partnership standards ought to meet and/or exceed industry standards. In addition to ADHS contractual standards, AHCCCS has specific standards for plans. These standards should be adopted for the physical health care of those individuals as part of the integrated program for individuals diagnosed with a SMI. Similarly, CMS offer standards that should be adopted for the dual eligible populations that are part of the program. The HEDIS and Medicare standards are referenced below:

HEDIS Measures link:

http://www.ncqa.org/Portals/0/HEDISQM/HEDIS2014/List%20of%20HEDIS%202014%20Measures.pdf

Medicare Access to Care link:

http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/mc86c04.pdf

5.11. What are the current barriers for health information system and technology that support the sharing of individual health information for improved care coordination and health outcomes, and what steps can be taken to overcome them?

Sharing Individual Health Information for Improved Care Coordination/Health Outcomes

The State of Arizona has already adopted a uniform Health Information Exchange that all RHBAs follow. All RHBAs adhere to these requirements. Magellan believes this is a very effective system that should serve this program well. The Meaningful Use requirements have already established the uniform connectivity for transferring data and for the integration of data. We do not foresee any barriers for the health information system and the technology that support the sharing of individual health information for improved care coordination and health outcomes that exists today.

5.12. What is the most effective way to engage the community and stakeholders in Greater Arizona, and how should a RBHA be held accountable to those parties?

Strategies for Community and Stakeholder Engagement

ADHS/DBHS already has an established, well organized, and outlined Community Engagement framework. It is recommended that this same approach be replicated in Greater Arizona as a requirement. This strategy, as it was outlined before the Arizona Behavioral Health Planning Council in October, 2013, involves three phases: (1) public forums to elicit input from peers and family members, (2) meetings with acute care providers, and (3) RBHA input and responsibility.

In addition to this engagement strategy, ADHS/DBHS has current expectations around collaborative meeting structures and operating protocols that act as vehicles for stakeholder engagement, participation, and service delivery in partnership with the RBHAs.

Based upon these well established expectations, the RFP should call for each bidder to respond as to how they will build from these successful, known strategies and further enhance and advance the system through community engagement. It should also be required for each bidder to further address considerations for the unique needs, demographic make-up, and culture of each geographic region as part of their application of community engagement.

5.13. How should stakeholders such as courts, detention centers, school systems and colleges be engaged as an evaluator of RBHA performance?

Evaluators of RBHA Performance

The state would benefit from utilizing multiple stakeholder groups in many areas of evaluating RBHA performance. Stakeholders offer a distinct and unique view of how an RBHA is performing, often with direct experience in the communities, institutions and schools where members are interacting on a daily basis. The involvement of stakeholders would be most effective if they were engaged throughout the RBHA contract-evaluation process.

At the start, a diverse group of stakeholders should be included in the RBHA selection committee to ensure program design takes into account the importance and intersection of the behavioral system with other programs and services. Stakeholders should continue involvement in

monitoring RBHA performance throughout the program tenure in both formal and informal venues including participation on governance boards and quality committees, as well as annual reviews, satisfaction surveys, round-table discussions, and review of performance data.

5.14. What payment models should be considered to incentivize health outcomes, access to care, and cost efficiency for Greater Arizona?

Incentivizing Health Outcomes, Access to Care, and Cost Efficiency through Payment Models

Payment models to incentivize health outcomes, access to care, and cost efficiency is a multi-level approach including incentives for RHBAs, providers, and individual members. In order for incentives to be effective they need to be aligned across the systems to reach these desired outcomes. Incentives should be implemented in a way that does not withhold payments based upon funding for RHBAs or providers but rather rewards exceptional performance. We would recommend that ADHS request from the potential RFP bidders what they would propose and how they would implement these incentive models for providers and members.

5.15. How could the community be utilized to its maximum advantage to support a recovery based system in Greater Arizona?

Maximizing Community Support for a Recovery Based System

We suggest that ADHS require potential RFP bidders to present models for maximizing the recovery based system in the Greater Arizona configuration. Emphasis should be placed on the models that include families and communities in the process.

---

6. RESPONDENT CONTACT INFORMATION TO BE INCLUDED IN THE RESPONSE

Contractor	Magellan Complete Care of Arizona, Inc.
Attention	James R. Stringham, Senior Vice President
Address	4801 East Washington Street
Address	Suite 100
City, State, ZIP	Phoenix, AZ 85034
Phone	(602) 652-5955
Fax	(888) 656-4221
Email	JRStringham@magellanhealth.com
Website	magellanhealth.com magellancompletecareofaz.com